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China engages global health governance: Processes and dilemmas

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Using HIV/AIDS, Severe Acute Respiratory Syndrome (SARS), and avian influenza as case studies, this paper discusses the processes and dilemmas of China's participation in health governance, both at the domestic level and the global level. Globalization has eroded the boundary between public and private health and between domestic and global health governance. In addition, the SARS outbreak of 2002–2003 focused global attention on China's public health. As a rising power with the largest population on earth, China is expected by the international community to play a better and more active role in health management. Since the turn of this century, China has increasingly embraced multilateralism in health governance. This paper argues that China's multilateral cooperation is driven by both necessity and conscious design. International concerns about good governance and its aspiration to become a 'responsible' state have exerted a normative effect on China to change tack. Its interactions with United Nations agencies have triggered a learning process for China to securitize the spread of infectious diseases as a security threat. Conversely, China has utilized multilateralism to gain access to international resources and technical assistance. It is still a matter of debate whether China's cooperative engagement with global health governance can endure, because of the persistent problems of withholding information on disease outbreaks and because of its insistence on the Westphalian notion of sovereignty.

Keywords: China; infectious diseases; global health governance; WHO; sovereignty

Introduction

In the past quarter century, China's economic reforms have brought opportunities and prosperity to many Chinese citizens. As a consequence of the adoption of the reform and opening-up policy, urbanization has grown and trade and travel between China and the rest of the world have expanded. A potential danger of China's increasing connections with the world, and the concomitant rising mobility of its people, is the acceleration of the global spread of infectious diseases. Another unfortunate development is that, in sharp contrast to the stunning success of economic reforms, China's public health reforms have left the country with a backward public health system. With Deng Xiaoping's dictum, 'to get rich is glorious', the government acted single-mindedly in economic pursuit, to the detriment of social infrastructural development. Anything which was thought likely to increase production cost, and consequently to undermine economic

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development, was deemed undesirable and unacceptable. With this kind of philosophy, public health was given only a relatively low priority in the government's national development plan. As a consequence, people's rights to basic health services are no longer guaranteed. Poor people are less likely to get access to medical services or the modern healthcare system. In a world health report entitled 'Health Systems: Improving Performance', published by the World Health Organization (WHO) in 2000, China's healthcare system was ranked 188th on the dimension of fairness of financial contribution.¹

Apart from being unfair, the operation of the health system has been opaque. Due to market-related concerns, government officials are worried about the negative impact of the revelations of any outbreak of disease inside China. The outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002–2003 was a wake-up call for China, as well as the international community, on the importance and seriousness of China's approach to health governance. China, a rising power with the largest population on earth, is expected by the international community to play a better and more active role in health management.

Since the turn of the century, China has increasingly embraced multilateralism in global health governance. This engagement has deepened since the SARS outbreak. This paper examines the processes and dilemmas of China's engagement in global health regimes. First, it provides some background information about globalization and public health. It then focuses on China's public health by examining the extent to which China deals with health issues through multilateral cooperation. The paper then discusses the processes and dilemmas of China's participation in health governance at the domestic as well as the global level, using three cases involving HIV/AIDS, SARS, and avian influenza (known also as 'bird flu', 'H5N1', and 'avian flu'). Based on the empirical examination of these cases, the paper attempts to theorize China's participation in global health governance before drawing some conclusions.

Globalization and public health

Microorganisms do not recognize or respect national boundaries, especially in a highly globalizing world. Infectious diseases can readily spread from one country to another and, indeed, from one continent to another, posing direct threats to national and human security, as evidenced by the spread of such contagious diseases as HIV/AIDS, SARS, and avian flu. Many new and resurgent pathogenic viruses have the capacity to reach anywhere in the world within 24 hours. They can have a destructive effect on state capacity, national prosperity, and effective governance. Public health can no longer be perceived as a domestic issue, separated from foreign-policy concerns. It is now widely considered a non-traditional security threat with a global dimension. Lincoln C. Chen and his colleagues argue that globalization is eroding the boundary between the determinants of public and private health (Chen et al. 1999). The late Jonathan Mann, former head of the WHO Global Programme on AIDS, said that 'the dramatic increases in worldwide movement of people, goods, and ideas is the driving force behind the globalization of disease . . . health problems in any part of the world can rapidly become a health threat to many or all' (quoted in Garrett 1994: xi–xii). It is little wonder that the fight against infectious diseases

constituted one of the priority areas of the Group of Eight summit meeting held in St. Petersburg, Russia, in July 2006.

In the present globalized world, no single state has the ability to contain and control a highly lethal infectious disease on its own. A country's public health and its policies could have dire consequences for itself as well as the international community. Public health governance or international health governance has primarily been focused on the national level. Under the Westphalian concept of governance, the state has supreme power over its internal affairs. According to the principle of consent-based international law, states have no legal obligation to involve international institutions in addressing a health crisis within its territory. Cooperation and compliance with the International Health Regulations of WHO depend very much on the goodwill of governments. In this respect, the international community has little or no legal basis to condemn China for its denial of entry of a WHO delegation at the early stages of the SARS outbreak (Fidler 2004).²

Given the deterritorialization nature of globalization, the issue is how to manage borderless microorganisms in a borderless world. Health issues are at the forefront in the study of global politics in the twenty-first century.³ Some International Relations scholars have called for a post-Westphalian form of governance in managing pathogenic diseases (Fidler 2004, So and Ngai 2004). They are sceptical about the usefulness of the state-centric, Westphalian approach to public health. For instance, in his study of the SARS outbreak, David Fidler (2004) concludes that 'Westphalian public health' principles failed to combat the outbreak. Public health should no longer be considered as a medical and social issue alone, but also as a security issue that needs a more effective mechanism to address it. In order to manage health issues more effectively in a globalizing world, health governance requires a fundamental transformation of the understanding of national sovereignty. As Richard Dodgson and Kelley Lee (2002: 99) have argued, there is a need to 'deterritorialize health ... by going beyond the primary focus on the state'.

This post-Westphalian global health governance seeks to promote human health by the provision of global public goods for health. Strictly speaking, health per se is not a public good, but the prevention or containment of infectious diseases is non-rivalrous (i.e. letting nonpayers enjoy the benefits creates no cost to the payers) and non-excludable (i.e. it is difficult to exclude nonpayers from the benefits). With these distinctive characteristics, the prevention and containment of infectious diseases can be considered a global public good (Zacher 1999, Woodward and Smith 2003). Conversely, any belated response or negligence in the prevention and containment of infectious diseases can be deemed to be a global public bad.

Global health governance is premised on the taking of collective actions, by a range of actors, with the aim of tackling health problems, and of promoting and protecting the health of populations through the making and implementation of global norms and rules. It needs to 'recognize and give meaningful participation of a greater plurality of interests to capture both the territorial and supraterritorial features of global health issues' (Dodgson and Lee 2002: 100). The state should not be the only actor, but rather part of a wider system that involves non-state actors, including international and local nongovernmental organizations (NGOs), corporations, private foundations, and individual activists. Infectious diseases can only be contained and defeated by state and non-state actors cooperating with each other and responding promptly and decisively. At issue is whether and how states deal with

health issues through multilateral cooperation and participation in global health governance.

Why China's public health?

There are four reasons for investigating China's public health: (a) the escalating tension between China's traditional Westphalian concept of world order and the demand for a post-Westphalian health governance; (b) a general neglect of China's health governance in the discipline of International Relations; (c) international scepticism of the true situation of China's public health; and (d) China's ailing healthcare system.

China's traditional state-centrism

Traditionally, China has perceived public health as a domestic social issue, and has played down its international implications. Its response to the SARS outbreak, in early 2003, resonated well with the Westphalian concept of handling public health issues. Although China has stepped up its integration with the rest of the world over the last two decades, it still steadfastly resists any international intervention in its internal affairs. While China has modified its approach to health governance, and increased rapidly its participation in global health regimes since the SARS outbreak, its health governance, both domestic and global, has remained largely 'state-led'. The country has been seriously criticized for its maladministration of the SARS outbreak and for its lack of commitment toward global health governance. One of the challenges China is facing is how to accommodate the demands for post-Westphalian health governance while upholding its state-centrism.

General neglect of China's health governance in International Relations

Over the past decade, there have been a growing number of studies about China's external behaviour and its involvement with international institutions. The majority of these studies focus on its participation in United Nations (UN) peacekeeping missions (Kim 1999), arms control (Johnston 1996, Swaine and Tellis 2000, Frieman 2004), human rights (Kent 1999), and international finance and trade (Economy and Oksenberg 1999, Pearson 2000, G. Chan 2004, G. Chan 2006). There are also studies which examine the impact of international actors working within China on environmental issues (Economy 2004, Morton 2005). However, there is a general neglect in the international relations scholarship of health governance in China as well as its participation in global health governance. Crucial issues, such as the extent of China's involvement in global health governance, and the consequences of such involvement for China as well as the world, are under-assessed. This paper argues that a careful analysis of China's record of compliance and non-compliance, with global health regimes, can help to increase our understanding of its role in the international community and the processes and dilemmas of its international engagement.

International scepticism of China's health situation

The three large-scale outbreaks of pandemic viruses in the twentieth century (the 1918 Spanish influenza, the 1956 Asian influenza, and the 1968 Hong Kong influenza) were widely believed to have originated in Asia (McIlroy 2003).⁴ The 1918 influenza pandemic killed more than 20 million people worldwide. The 1956 and 1968 influenza originated in southern China and, ultimately, spread across the globe and killed two to five million people worldwide (Ricci 2006). More recently, SARS, the first severe global epidemic in the twenty-first century, also first appeared in Guangdong, southern China. Owing to China's denial and concealment in the first several months, SARS rapidly spread around the world and led to panic across countries.

Due to China's non-transparency, the international community treats China's health reports with scepticism. Some even suspect that SARS may be a prelude to another, even more dangerous, pandemic from China (Kleinman and Watson 2006). If we do not want history to repeat itself, SARS may serve as a wake-up call for policy-makers, as well as academia, to pay more attention to China's health governance. As Kleinman and Watson (2006: 1) claim, 'SARS need not be the prelude to something far worse if governments and public health agencies learn from the events of 2003'. To avert another outbreak of health disaster, we need to understand the processes and dilemmas of China's engagement in global health governance.

China's ailing healthcare system⁵

During Mao's revolutionary era, China's healthcare system was comparatively more equitable and effective than it is now, with the provision of basic medical care for all. Its healthcare system then was often praised as a model for the Third World. Along with economic reforms, China's public health system has, since the early 1980s, switched to a user-pay, market-oriented system. While it is true that scientific and medical skill has improved as a result of the reform, overall, China's medical reform has been a failure in terms of public access to medical care. Under a user-pay health system, people's basic health rights are no longer guaranteed. In many rural areas, public health services have almost collapsed. The Chinese Academy of Social Sciences published in May 2006 a report entitled *Zhongguo yiliao weisheng fazhan baogao*, commonly known as *The Health Care Green Book*, explicitly attributing the sorry state of the country's public health system to the dearth of government financial support. The report says that the government should bear the primary responsibility for this failure (Du et al. 2006).

More seriously, the present health system is an emergency system; it does not form an effective regular system that would include such measures as the prevention and treatment of contagious diseases (China AIDS Survey 2006). With the implementation of the 'management responsibility system', there has been a shift of emphasis in hospitals from preventive care facilities to those that can make profit. Many anti-epidemic stations and preventive care institutions have shrunk accordingly (Hu and Jiang 1998).⁶ As a consequence, some infectious diseases, such as tuberculosis and schistosomiasis, have resurfaced in rural areas.⁷ China's ailing public health system has exposed its deficiencies and weaknesses in controlling such

emerging infectious diseases as hepatitis, tuberculosis, HIV/AIDS, SARS, and avian flu. It has been argued that China is now facing a significant health security challenge and that its security threats are largely domestic in nature (Thompson 2004).

The tarnished image of China's healthcare system has led some local officials to refrain from disclosing information about outbreaks of disease in their localities. Particularly fearful of scaring foreign investors and tourists, they are often at pains to cover up. Those brave and defiant enough to expose the truth about infectious diseases have often been scolded for being unpatriotic and 'anti-government'.

China's participation in global health governance

Since the dawn of the twenty-first century, there has been a remarkable change in China's public health policy, from denials and cover-ups to being more proactive and embracing multilateralism in managing its looming health crisis. Toward the end of the last century, particularly during and after the Asian financial crisis of 1997–1998, China began to be concerned about its international image. It not only uses a multilateral approach to deal with various international issues, but also aspires to portray itself as a responsible state in the global community. In the health realm, the central government has been paying more attention to health issues at the domestic level as well as on the international front.

The ailing state of China's health system has been officially admitted by the government. In August 2005, a joint report issued by the State Council's Development Research Centre and the World Bank pointed a finger at China's public healthcare system for its failure to prevent and control both serious chronic diseases and infectious diseases (China AIDS Survey 2006). This might be the first official criticism levelled at the public healthcare system.

Two perspectives can be used to evaluate China's role and nature of its involvement in global health governance: the internal and the external dimension. As Raimo Väyrynen (1999: xi) argues cogently, 'Global governance cannot replace the need for good governance in national societies; in fact, in the absence of quality local governance, global and regional arrangements are bound to fail or will have only limited effectiveness'. The following section, therefore, investigates China's response to its public health crises and its domestic governance of the three diseases, followed by an examination of its role in regional and international fora.

HIV/AIDS

Since the first reported case of AIDS in China in 1985, the Chinese government had concealed or denied the existence of an AIDS crisis in the country for more than 15 years. China's transparency problem in revealing the real situation of HIV/AIDS has often been reported by various sources. One example is its denial of an outbreak in central China among farmers who contracted HIV/AIDS through a dubious government-sponsored, blood-selling programme in the early 1990s. In June 2001, the central government finally admitted the problem of HIV/AIDS, and began to be increasingly concerned about the negative impact of the pandemic on society as well as the economy. According to UN agencies and the Chinese government, which released the latest official figure in early 2006, the estimated number of HIV carriers

in China is 650,000 (MOH et al. 2006, Yardley 2006).⁸ The overall HIV prevalence in the country is not high, at approximately 0.05%. However, the UN agencies warn that the new infection rate of HIV in China shows no signs of abating. In 2005 alone, there were 70,000 new cases of HIV in the country. To make things worse, the disease tends to have spread from high-risk groups to normal citizens (Ma 2006a).

Domestic governance

Since China admitted the problem of HIV/AIDS in 2001, and especially since late 2003, there has been a striking increase in its commitment to tackling the disease both domestically and internationally. Domestically, Premier Wen Jiabao and President Hu Jintao paid high-profile visits to AIDS patients in December 2003 and in November 2004, respectively, indicating that the central leaders wanted to show that they were taking the issue seriously.⁹ In February 2004, a new State Council AIDS Working Committee was established under the leadership of Vice Premier Wu Yi to coordinate and promote collaboration among government agencies, the private sector, and civil society (State Council AIDS Working Committee Office and UNAIDS in China 2004). During the National People's Congress meeting in March 2005, Premier Wen Jiabao reiterated the central government's determination to improve China's public health system, particularly in fighting HIV/AIDS. In June 2005, in an executive meeting of the State Council, the prevention, treatment, and care of HIV/AIDS was highlighted as one of the key public health areas of the 11th National Five-Year Plan (2006–2010). Each level of government was requested to standardize HIV/AIDS prevention and care work in accordance with the law (MOH et al. 2006).

China not only has revised its Law on the Prevention and Control of Infectious Disease, and implemented regulations on AIDS prevention and control, but has also drawn in a multiplicity of actors, state and non-state, to combat the disease.¹⁰ China has called on the private sector to join its fight against the disease. In a summit on AIDS, jointly hosted by the Ministry of Health (MOH) and the Global Business Coalition on HIV/AIDS, in Beijing on 18 March 2005, Vice Premier and the then Health Minister, Wu Yi, urged private companies and NGOs to play a larger role in halting the spread of HIV/AIDS in China. This was the first time the Chinese government called for public–private partnerships in managing its health crisis.

Nevertheless, gaps between words and deeds exist in China's health governance. China's transparency problem in revealing the real situation of HIV/AIDS stands out and has been criticized by specialists and activists. While the Chinese government now openly admits the problems and challenges of HIV/AIDS, and allows the involvement of civil society in the campaign to combat it, ample evidence shows that AIDS activists are still penalized or kept in detention for leaking any negative information about the disease in localities. According to Human Rights Watch (2005), NGOs and AIDS activists in China continue to face detention and harassment by local authorities, especially in Henan province. The plights of Dr. Gao Yaojie,¹¹ Wan Yanhai,¹² and Li Qianji,¹³ offer vivid examples.

In evaluating its national HIV/AIDS prevention, treatment, and care policy, both the Chinese government and UN agencies conclude that China still faces a number of key challenges. Problems are particularly acute in localities where leaders often do not understand sufficiently the dangers of HIV/AIDS, and the implementation of the

'Four Frees and One Care'¹⁴ policy remains relatively ineffective in some areas. Henan province has several notorious 'AIDS villages' in which farmers contracted HIV/AIDS through dubious blood selling sponsored by local governments in the 1990s. Shangcai is one of the most seriously affected counties in the province. After the exposure of the AIDS crisis there, both the central and local governments have pledged to provide medical aid and financial support in order to improve the situation. However, it was alleged that by paying lip-service to supporting the central government's policy on 'Four Frees and One Care', local officials siphoned off aid money and resources, giving little to the patients and the people in need. More seriously, all of the charity gifts donated by various organizations could scarcely reach HIV/AIDS carriers or their families. Dr. Gao Yaojie called on aid groups and people sympathetic to the victims *not* to raise and offer any aid to Shangcai county, as local officials would embezzle it. She said that Shangcai county's policy on HIV/AIDS prevention and control was no more than a trap (Jiang 2006, Savadove 2006).¹⁵ Victims and activists have resentfully expressed that the officials in Henan who oversaw the blood-selling scheme have not been punished, but instead been promoted. Some remain politically powerful, not only in the province but also at the national level (Pomfret 2003, Spencer 2004, *The Economist* 2007).

This view was echoed by Joel Rehnstrom of the Joint UN Programme on HIV/AIDS (UNAIDS) China Office, who warned that the State Council Working Committee on AIDS 'hadn't quite really lived up to expectations' in effective coordination with lower-level authorities, although the central government has been increasingly open in handling the disease (*South China Morning Post* 2006). Peter Piot, executive director of UNAIDS, also noted that there was a mismatch between national policy made by the central government and its enforcement at local levels. He asserted that patients and NGOs should be given more room for involvement in the fight against the disease (Blanchard 2006a).

Global governance

On the international front, China has been playing a more active role in various international and regional fora since the early 2000s. It has participated in the Global Fund to Fight AIDS, Tuberculosis, and Malaria (hereafter, the Global Fund), the ASEAN+3 Seminar on Enhancing Cooperation in the field of Non-Traditional Security Issues, ASEAN+1 Ministers of Health Seminar on fighting HIV/AIDS and Influenza, the International AIDS Conference, and the International Congress on AIDS in Asia and the Pacific, in addition to various UN conferences. Chinese leaders have reiterated China's promise to play an active role in the regional and global efforts to combat the disease. For example, at the 15th International AIDS Conference, held in Bangkok in 2004, Chinese Premier Wen Jiabao pledged to contribute to the regional and global fight against HIV/AIDS (Altman 2004, *China Daily* 2004).¹⁶ Again, at a high-level meeting on HIV/AIDS at the 59th Session of the UN General Assembly, held on 2 June 2005, China reiterated its commitment to the international society in combating HIV/AIDS. A month later, Chinese delegates attended the Seventh International Congress on AIDS in Asia and the Pacific in Kobe, Japan.

Apart from participating in international and regional fora, China has also actively played host to a number of international conferences on the disease,

including a '2005 New Strategies on Prevention and Control of HIV/AIDS International Conference' in December 2005 (MOH 2005b), a gathering of 21 Asia-Pacific Economic Cooperation (APEC) economies, to reaffirm their commitment to fighting and controlling infectious diseases, in April 2006 (MOH 2006a), and a conference on 'East Asian Regional Cooperation to fight AIDS, Tuberculosis, and Malaria' in July 2006 (MOH 2006b). China's effort to fight HIV/AIDS also extends to the African continent. For some time, China has sent medical practitioners to help establish health care systems and has provided medical assistance and equipment to many African countries. More recently, it has provided generic HIV/AIDS drugs at affordable prices (*Ta Kung Pao* 2005, MOH 2006c, *Zhongguo yiyao bao* 2007).

As a consequence of enhanced collaboration between China and other governments and international organizations, there are cooperation programmes in 27 of China's 31 provincial units (provinces, autonomous regions, and municipalities of provincial ranks) (Gill 2006: 5). Conversely, Chinese officials, particularly those at subnational levels, have been at pains to stress the state-led nature of the cooperation programmes, and to prevent prominent AIDS activists from any engagement with the rest of the world. Events taking place in the worst-hit province of Henan are illustrative. The provincial health authorities have, since early 2003, blocked Medecins Sans Frontieres (MSF) from operating an HIV/AIDS treatment project in the province (S.S. Chan 2006). Dr. Gao Yaojie was blocked in February 2007 from leaving the country to receive a human rights award in the USA. The Vital Voices Global Partnership, a US advocacy group promoting female empowerment, informed Gao in October 2006 that she would be honoured in its March 2007 banquet in Washington, DC. US Senator Hillary Rodham Clinton is an honorary co-chair of the group.¹⁷ When Gao was about to leave Zhengzhou for Beijing in early February 2007 to process a travel visa at the US Embassy, she was placed under house arrest by Henan public security officers after senior provincial officials, including Deputy Governor Chen Quanguo, allegedly failed to persuade her not to attend the event and to meet Hillary Clinton. Gao had been prevented from receiving two overseas awards in 2001 and 2003 (Kwok 2007, *Reuters* 2007, Yardley 2007).

SARS

If HIV/AIDS is one of the most severe plagues of the twentieth century that continues to affect us today, then SARS could be seen as the first global epidemic of this century. From its emergence in November 2002 in Guangdong, China, the disease sped along the air routes of the globalized world. Within months, it had spread to 31 countries and every continent (Abraham 2005). Thanks to the timely and adequate cooperation by governments and international institutions, this lethal and contagious disease was contained in 8 months. On 5 July 2003, WHO declared that the disease had been contained worldwide (WHO 2003). The assertion that SARS is 'the world's first post-Westphalian pathogen', not only indicates that the traditional state-centric idea of international relations is no longer effective for combating the borderless infectious diseases, but also calls for a new type of public health governance, a more institutionally robust international public health structure in the era of globalization (Fidler 2004: 7–8).

Domestic governance

With respect to China's handling of SARS, the Chinese government, particularly its Ministry of Health and Guangdong officials, initially downplayed the severity of the disease, and suppressed information about the outbreak, while it spread out from southern China to other Chinese provinces, as well as overseas countries. China's belated response, and particularly its obstruction of the entry of WHO assessment teams into China for investigation of the virus in early 2003, was severely criticized by the international community. Not until more than 300 people had died, with more than 5,000 cases of infection in nearly 30 countries, and the real situation inside Beijing had been exposed by *Time* magazine in April 2003, did China's strategy of handling the outbreak shift (Greenfeld 2006). In a Politburo meeting on 17 April 2003, the new leadership announced its heightened determination to fight the disease. After months of denial, China's attitude reversed and became more cooperative and proactive. The central authorities ordered all local governments to provide accurate, timely, and honest, reporting of SARS cases. Furthermore, at a press conference on 20 April 2003, the Chinese government admitted that confirmed cases of SARS in Beijing were nine times higher than the day before. In order to restore its credibility, China swiftly removed Health Minister Zhang Wenkang, and Beijing's Mayor Meng Xuenong, for negligence in dealing with the crisis. WHO teams were also granted access to Beijing, Guangdong, and other places in China to investigate the pandemic of this atypical pneumonia. Premier Wen Jiabao described SARS as a grave threat, and reiterated that China was willing to cooperate with all infected countries to tackle the disease, and urged local governments to remain transparent in handling the crisis (Wang 2003, White 2003, Saich 2006a).

Having acknowledged the SARS outbreak in Beijing and Guangzhou, Chinese leaders implemented a more proactive and open policy to cope with the crisis. Vice Premier Wu Yi was appointed Minister of Health to oversee the management of a special SARS task force. This was the first time that the Chinese government appointed such a high-ranking and prestigious official to head the Ministry of Health, showing the government's determination to remedy the situation.¹⁸ The new leadership, led by President Hu Jintao and Premier Wen Jiabao, made a visible gesture toward supporting the government's openness in combating the disease. In order to encourage more concerted efforts in fighting this lethal virus, Hu inspected SARS-affected cities of Tianjin, Guangzhou, and Shenzhen, in mid-April 2003, while Wen visited SARS-stricken universities, hospitals, shopping malls, and residential communities in Beijing in late April 2003 (Xinhua News Agency 2003b).

Global governance

On the international front, before the SARS outbreak, China endorsed the ASEAN-Disease-Surveillance.net network in September 2000 (SEANIDOS), and the APEC Infectious Diseases Strategy in October 2001 (APEC 2001), and pledged to facilitate regional cooperation to improve surveillance of infectious disease outbreaks. However, the SARS outbreak of 2002–2003 demonstrated that China did not follow these surveillance measures closely. On 22 March 2003, the WHO regional director in the Western Pacific Regional Office, Shigeru Omi, urged China, fruitlessly, to increase transparency in information sharing about the outbreak in Guangdong, in a

one-to-one meeting in Hong Kong with China's then Minister of Health, Zhang Wenkang. Thus, 10 days later, the Beijing Office of WHO informed the Chinese government that it would issue that day a travel advisory against unnecessary travel to the province (Foreman 2006, Omi 2006).

A rather weird event happened at the end of April 2003. The ASEAN member states, initiated by Singapore, held a 'Special ASEAN Leaders Meeting on SARS' in Bangkok with the aim of enhancing regional collaboration in containing the spread of SARS in the region. Initially, China was excluded from the meeting. One week before it was convened, Thailand swiftly announced that Chinese Premier Wen Jiabao would join the summit in a 'Special ASEAN-China Leaders Meeting on SARS' on 29 April 2003 (Xinhua News Agency 2003a). It was widely believed that China took the initiative in approaching Thailand to make a request for participation in the summit. In his first international meeting after taking the office of premiership a month ago, Wen explicitly stated, 'I came here in a candid spirit [with a] responsible and trustworthy attitude to co-operate [with other countries]' (Chou Wiest 2003a). During the summit, in addition to signing a joint declaration on controlling the spread of SARS, China pledged to contribute 10 million yuan (US\$1.2 million) to set up China-ASEAN cooperation programmes for controlling SARS (Gang 2003, Vatikiotis 2003). Obviously, China's more proactive cooperation was an effort to remedy its tarnished international reputation, and to relieve the pressure from the international community during the SARS outbreak.¹⁹

Subsequently, China has proactively participated in various ASEAN regional fora, such as the 'ASEAN + 3' Ministers of Health Special Meeting on SARS in April 2003 in Kuala Lumpur and, again, in Siem Reap, Cambodia, in June 2003. During the meeting in Kuala Lumpur, all members agreed to undertake several measures to fight the disease. They included the establishment of a 'hotline' network to facilitate communications in an emergency, for the exchange of information, and the carrying out of stringent pre-departure screenings at airports and seaports. In addition, at a regional conference held in the Philippines in mid-May 2003, China, Japan, South Korea, and all ASEAN members, with the exception of Myanmar, agreed to implement a number of standardized measures to stop the spread of the disease in the region (Guo 2003, Lo 2003). To further operationalize the ministerial directives agreed upon in the summit meetings, an 'ASEAN + 3 Action Plan on Prevention and Control of SARS and Other Infectious Disease' was adopted in June 2003.

As a member of the APEC forum, China threw its weight behind the APEC Action Plan on SARS. In the APEC Health Ministers' Meeting, held in Bangkok in late June 2003, Vice Premier and Health Minister Wu Yi affirmed the importance of international mechanisms, including APEC, the ASEAN, and WHO, in the global fight against SARS. She reiterated China's commitment to working closely with other APEC members (*China Daily* 2003). During the second 'Special ASEAN + 3 Health Ministers Meeting on SARS', in Siem Reap in the same month, ASEAN ministers praised China's 'utmost efforts to improve the quality and timeliness of surveillance', despite their belief that China could make further contributions to the global containment (ASEAN 2003).

This seemingly open and cooperative strategy in health governance has its limitations. Jiang Yanyong, a SARS whistleblower, initially received an official acknowledgement for prompting the Chinese government to launch a massive public health campaign to combat SARS (Friess 2003, Jakes 2003, Greenfeld 2006).²⁰ In

spite of that, not long after the acknowledgement, he was taken into custody. After it was announced that he would be awarded the Ramon Magsaysay Award in 2004, for his contribution to revealing the government's SARS cover-up in early 2003, he was barred from leaving the country to receive the award (S.S. Chan 2004).

Whether China's impulse to be more proactive in international fora was driven by a commitment to providing public goods for health, or was meant as a gesture to remedy its tarnished international reputation, or was a response to its domestic dangers, is still a matter of guesswork. However, the determined exclusion of Taiwan from WHO exemplifies China's position to uphold the principle of national sovereignty or supreme power over people and territory. Since 1972, Taiwan has been excluded from the World Health Assembly (the policymaking body of WHO) due to the 'one China policy' and political pressure from Beijing. So far, Taiwan's annual attempts to join the World Health Assembly as an observer since 1997 have failed (*China Daily* 2006a). The SARS outbreak in 2003 raised a concern, particularly from the perspective of Taiwan, about political intervention in providing global public goods for health. Denis Aitken, WHO assistant director-general, argues that under the memorandum of understanding on Taiwan, signed between Beijing and the UN health agency in 2005, information flow is fully covered on the island (Higgins 2006, Hille et al. 2006). Taiwan's health and medical experts can attend and participate in WHO technical activities, though with Beijing's consent. The agreement also allows WHO to send experts to Taiwan in emergency situations. Nevertheless, China is at pains to block any attempt by Taiwan to be an observer or member of WHO.

Avian flu

Avian flu captures global attention because its case-fatality rate is higher than other infectious diseases. Since H5N1 re-emerged in Asia in December 2003, the virus has already spread to 11 countries in four continents. As of 12 June 2007, a total of 190 people have been killed, representing almost 61% of reported human cases of infection since 2003. While Indonesia, Vietnam, and Thailand are the three hardest hit countries, the fatality rate in China of 64% is higher than the average of the 12 affected countries, and the death toll in China was the fourth highest, after Indonesia, Vietnam, and Thailand (WHO 2007). Health experts and WHO officials fear that a highly pathogenic avian influenza, H5N1 virus, may mutate into a form that is easily communicable among humans. The first laboratory-confirmed case of human-to-human transmission occurred in May 2006 in northern Sumatra, Indonesia, where seven people, of an extended family of eight, died of H5N1 (Rosenthal 2006a, *South China Morning Post* 2006). Although experts have asserted that human flu transfers could exceed more than those reported, WHO still maintains the pandemic alert system at level 3, which means 'no or very limited human-human transmission' (McNeil 2006a). However, the possibility for this human influenza pandemic to kill millions of people, and cause catastrophic economic consequences, cannot be underestimated. On 20 December 2005, China and WHO signed a cooperative deal, by which China would be committed to being transparent in sharing samples of human flu viruses with the UN agency (Zhang and Zhao 2005). The question is, will China comply fully with this agreement?

Domestic governance

The SARS outbreak triggered a learning process whereby officials at all levels have been alerted to the importance of transparency in tackling public health crises. Officials explicitly admitted that the government had learned from the SARS outbreak and had tried to strengthen its disease surveillance system. In response to questions as to whether or not Chinese officials had attempted to cover up the bird flu cases, Cai Wu, Director of China's State Council Information Office, commented in Australia in April 2006, that 'some high-ranking officials in China paid a very high price' in managing the SARS crisis, and that the Chinese government 'asked officials to release information on bird flu in a very timely manner' (Fitzsimons 2006). China's initial response to the outbreak of this highly pathogenic avian influenza was more open and cautious than its previous responses to infectious disease outbreaks. Since the avian flu issue was raised in the international community in 2005, China has organized an aggressive campaign to stem the outbreaks.

In March 2006, the Ministry of Health issued a sharply worded statement warning local officials that any cover-up or deliberate delay in reporting could risk spreading the disease. While denying any cover-up of bird flu, China acknowledged that there were delays in releasing information at local levels (Ma 2004, Zamiska 2006b,c). Officials from WHO also noted China's improvement in epidemic notification and transparency in urban areas. Nevertheless, local farmers might be reluctant to report infections because of the lack of financial compensation (Lee 2006). Overall, problems with notification are largely due to the insufficient and poor technical surveillance system, and China 'did not do it deliberately', according to Christianne Brusckhe, head of the bird flu task force at the World Organization for Animal Health (Rosenthal 2006b).

The implementation of national plans to fight the avian flu, however, meets several obstacles. In China, many vaccines available from the market are not reliable. For instance, it was reported that unlicensed vaccines were sold to farmers in Liaoning, a northeastern province (Sipress 2005). After bird flu began killing chickens across the province in late 2005, officials quietly distributed an old antiviral drug, which was made with amantadine and available in abundance, as a pre-emptive method to prevent it. Scientific evidence has shown that the majority of bird-flu strains circulating in Asia are resistant to amantadine. This incident has already bred concern from WHO, which declared that 'the mass use of antiviral drugs prophylactically is not something the WHO would advise' (Zamiska 2006a). While fake vaccines leave poultry unprotected, substandard vaccines could be even more dangerous. They cover the symptoms of bird flu without blocking the virus. Poultry become silent spreaders, making it even harder for farmers and experts to monitor, control, and prevent any outbreak.²¹ It has been widely believed that China lacks the resources and basic hygiene precautions and administration to avoid improper inoculation.

Global governance

China's participation in the global fight against avian influenza has also been proactive. It has attended various regional and global summits that deal with the pandemic. A joint statement, which China signed with 13 Asia-Pacific countries in

November 2004, was an important step in enhancing multilateral cooperation in addressing the avian-flu crisis (*Straits Times* 2004). In order to facilitate cooperation and sharing information and data, China and the 20 other APEC members endorsed the Action Plan on the Prevention and Response to Avian and Influenza Pandemics in May 2006, during an APEC forum in Vietnam (Krause 2006, Xinhua Online 2006).

There are, however, competing observations relating to China's compliant and proactive behaviour. China's efforts to cooperate with international institutions in preventing and controlling bird flu have been praised by the international community. UN health officials agree that China has been honest with the international community about its latest outbreaks of bird flu (*South China Morning Post* 2005). Together with the World Bank and the European Commission, the Chinese government organized an International Pledging Conference on Avian and Human Influenza, in Beijing on 17–18 January 2006, with the aim of calling on various countries to provide financial support to combat avian influenza. Lee Jong-Wook, then Director-General of WHO, commented that China's central government was committed to sharing information about bird flu cases. By hosting international conferences, the Chinese government also wanted to show its commitment to information sharing and global responsibility.²² China's commitment to combating avian flu was commended by the US government; Elias Zerhouni, Director of the National Institutes of Health of the United States, said in her visit to Beijing in December 2005, that Chinese scientists and government leaders had been completely open in providing information on the H5N1 virus (Enav 2005).

In contrast, China seems reluctant to share, with WHO, crucial information on the development of H5N1. Despite the fact that the health organization urges China to give it more virus samples, China has offered little since 2004, until shortly after Margaret Chan, a Hong Kong Chinese citizen, was elected head of the organization in November 2006.²³ Gaps in China's bird flu reporting system became apparent in late June 2006, when eight Chinese scientists wrote, in the *New England Journal of Medicine*, that a 24-year-old soldier, admitted to a Beijing hospital in November 2003, died of H5N1 in early December 2003, having initially been diagnosed as SARS-infected. WHO asked the Chinese government for information about the discrepancy, but received only a lukewarm response. Its Ministry of Health said on 10 July 2006, 2 weeks after the publication, that it was waiting for the results of tests carried out on the soldier. More confusing still, after the report on the findings was submitted to the journal, one of the scientists allegedly asked for its withdrawal (Benitez and Ma 2006, Ma 2006b,d, McNeil 2006b, *The Economist* 2006). Eventually, in late July 2006, Beijing invited WHO to send experts to take part in retrospective tests on the first possible human H5N1 death discovered on the mainland (Ma 2006e). The cause of the soldier's death was confirmed in early August 2006.²⁴ This incident overturns the initial understanding that the virus re-emerged in poultry in South Korea, in December 2003, and then spread to Vietnam in the same month.

Theorizing China's participation in global health governance

Several hypotheses can be formulated about China's changing governance policy on infectious diseases and improved compliance with global norms and rules²⁵:

- (a) rational utilitarian calculations, (b) securitization of communicable diseases, and (c) international concerns about good governance and self-projection as a responsible state.

Rational utilitarian calculations

China perceives multilateralism and global health governance instrumentally in terms of rational utilitarian calculations of tangible costs and benefits. As Yong Deng (1999) has argued, since the 1990s China's leaders have seen the virtue of multilateralism, and realized the importance of interdependence in the promotion of its national interests. By admitting that its ailing healthcare system is too fragile to control emerging infectious diseases, and by acknowledging deficiencies in handling its HIV/AIDS problem, China can gain access to international resources and technical assistance, and cement cooperation with international state and non-state actors. For instance, shortly before China adjusted its population of HIV/AIDS sufferers in 2001, it was in the process of submitting an application to the Global Fund for a grant worth US\$90 million.²⁶

Since its admission of the AIDS crisis, China has entered into cooperation with more than 20 international organizations and countries, which provide it with financial or medical assistance to prevent and control the epidemic (*China Daily* 2004). For example, China has collaborated with the US Global AIDS Programme since 2002, although the two governments do not always agree with each other on issues such as human rights and Taiwan. Northeast China's Heilongjiang province is one of the beneficiaries of such collaboration. Since June 2004, the US Global AIDS Programme has helped to set up 15 of the province's 21 HIV surveillance sites at disease control and prevention centres. The US government announced, in June 2005, that it would commit over US\$35 million for HIV/AIDS-related activities in China between 2006 and 2008 (Embassy of the PRC in Australia 2005). Financial and medical assistance has also come from such international institutions as the United Nations Children's Fund (UNICEF), the Clinton Foundation, the Global Fund, and the Global Business Coalition on HIV/AIDS.²⁷ In meeting Peter Piot of the UNAIDS in Beijing in September 2006, He Luli, vice-chairwoman of the Standing Committee of National People's Congress, said that China needs more support from the UN body to treat its AIDS patients and to prevent the spread of the disease (Xinhua News Agency 2006).

The Chinese government realizes that it also needs the help of the private sector to control the disease. In a summit on AIDS in Beijing, jointly hosted by the Ministry of Health and the Global Business Coalition on HIV/AIDS, in March 2005, Vice Premier and Health Minister, Wu Yi, urged private companies and NGOs to play a larger role in halting the spread of HIV/AIDS in China. This was an unprecedented move in calling for public-private partnerships in managing its health crisis. As of December 2005, a total of 26 international companies had already established, or had committed to implementing, non-discrimination policies for HIV/AIDS for their China-based employees (The Corporate Social Responsibility Newswire Service 2005). Apart from that, the Ministry of Health, Merck & Co., a pharmaceutical company, and the Merck Company Foundation have recently co-organized a project known as 'HIV/AIDS Community-Based Prevention Initiative'. They have invited private companies to participate, on a contracting-out basis, in

designing a community-based HIV/AIDS prevention and education programme in Zhaojue and Butuo counties, Sichuan province, where the rate of HIV/AIDS infection is high (MOH 2005a, Distlerath 2006). A public-private partnership, known as the China Health Alliance, was launched by the Global Health Initiative of the World Economic Forum in September 2006. The Alliance brings together private companies, the Chinese government, UN agencies, and NGOs to implement HIV and tuberculosis programmes for migrant workers in rural workplaces (*IPR* 2006, *Kaiser Daily HIV/AIDS Report* 2006).

In summary, because China is short of human and material resources in dealing with the deadly disease alone, it badly needs the participation of transnational actors. Cooperation with them could draw them into assisting the domestic campaign to halt the transmission of HIV. Acting out of this rational calculation of its interests, China is inclined to cooperate with various international organizations in tackling its HIV/AIDS problem.

Communicable diseases as an identifiable threat

Since 2000, the United Nations has played a critical role in securitizing HIV/AIDS, constructing the disease as a security threat that demands international attention and action (McInnes 2006). In January 2000, Kofi Annan argued, in a UN Security Council meeting on HIV/AIDS, that 'AIDS is causing socioeconomic crises which, in turn, threaten political stability' (Vienna International Centre of United Nations Information Service 2000). The first Security Council meeting in 2000, the first one in the new millennium, was also the first Security Council meeting that addressed a health issue. Five months later, the United Nations General Assembly (UNGA) not only reaffirmed the commitments to achieving gender equality, development, and empowerment of women, made earlier in the 'Beijing Declaration and Platform for Action', but also highlighted the need to combat HIV/AIDS as one of the 12 priority areas to achieve advancement and empowerment of women.²⁸ In July of the same year, the Security Council gave prominence to the security significance of the epidemic in the watershed Resolution 1308.²⁹ Subsequently, the UNGA adopted, in September 2000, Resolution 55/2, known as UN Millennium Declaration, calling for halting and reversing the spread of HIV/AIDS, particularly in Africa. The UNGA convened a special session on AIDS in June 2001, and adopted the Declaration of Commitment on HIV/AIDS (UN General Assembly 2000). In the following year, the Global Fund was established. With the UN devoting increasing awareness to the epidemic, the link between HIV/AIDS and insecurity had been established in international policy discourse and agenda.

Peter Piot proclaimed that HIV/AIDS is a catastrophe both from a public health perspective and from the perspective of its political and socioeconomic impacts. He stressed the need for political leaders to mobilize a multilateral response to HIV/AIDS (Piot 2000). As early as 1997, the UN Theme Group on HIV/AIDS warned in its report, 'China Responds to AIDS', jointly published with the Chinese Ministry of Health, that there would be a potential pandemic in China. If the government did not respond effectively, the total number of HIV/AIDS in China in 2010 could rise to 10 million (UN Theme Group on HIV/AIDS and Chinese Ministry of Health 1997).

The Chinese government came under further scathing attack by the UN Theme Group in 2002, for failing to contain or treat the disease. The UN Group said, in a

report entitled ‘HIV/AIDS: China’s Titanic Peril’, that China’s effort to stem the epidemic had an ‘infinitesimally small impact’ and that China was ‘on the verge of a catastrophe that could result in unimaginable suffering, economic loss, and social devastation’. The UN Group blamed a lack of commitment and leadership on the part of government officials, at many levels, and insufficient openness about HIV/AIDS for the slow progress in combating the disease (Chang 2002, Pan 2002).

It is likely that China’s long-standing, active interactions with various UN agencies have triggered a learning process whereby China modifies its understanding of the vulnerability of HIV/AIDS and, accordingly, defines it as an identifiable security threat. With a new conception of security that blurs the boundary between low politics and high politics, China has, since 2001, framed the looming HIV/AIDS epidemic as a global security issue rather than a domestic social issue.³⁰ The conceptualization of contagious diseases as security threats has gained strength since the SARS outbreak.³¹ Against this background, there is little wonder that Peter Piot was invited to the Central Party School of the Chinese Communist Party, in June 2005, to speak on the challenges of AIDS to society, to a group of promising central and local officials who were groomed for promotion by receiving short-term training programmes at the School (Piot 2005).

International community’s prodding on governance and self-projection as a responsible state

Another possible motivation for China to change tack is the normative pressure from the international community and its aspiration to become a ‘responsible’ state. Globalization is considered a ‘two-edged sword’ (*shuangren jian*) by Chinese leaders. While China proactively integrates itself into the globalized world, in pursuit of economic development, integration requires China to embrace a multilateral approach and the underlying values of global management. As Rosemary Foot has argued, when China started to rejoin the international society in the late 1970s, the criteria of a responsible state were being changed from pluralist to solidarist concepts whereby ‘common values and some notion of the common good’ were given priority (Foot 2001). The notion of ‘good governance’ and the associated ‘Washington Consensus’, which originated in the Washington-based international financial institutions, have later been embraced by the United Nations and other international development agencies, such as the World Bank and the Asian Development Bank (ADB) (World Bank 1992, 1994, Asian Development Bank 1995). The World Bank emphasizes the institutional environment in which the development process takes place and, accordingly, brings to the fore the ingredients of effective management of the development process. The ADB further consolidates the concept of good governance by identifying four elements: accountability, participation by stakeholders, predictability based on the rule of law, and transparency in information flow about government policy and decisions. Before the Asian financial crisis of 1997–1998, the ADB (Asian Development Bank 1995) warned, in its report ‘Governance: Sound Development Management’, that governments in the region had not yet established direct correlation between the political environment and rapid economic growth and social development. Since the financial crisis, the demand for transparency in the disclosure of information in government decision-making and public policy implementation has reached its

zenith. The United Nations Development Programme has specifically asserted that good governance is crucial for combating HIV/AIDS (Hsu 2000, UNDP 2002).

Poor transparency in Chinese government decision-making has always been highlighted for criticism by the international community. International NGOs have often claimed that China under-reports the seriousness of its HIV/AIDS problem. At the end of the twentieth century, there were many castigating reports about China's 'AIDS villages' in Henan. China's maladministration of the SARS outbreak further exacerbated other countries' scepticism of China's responsibility to the international community. During the SARS outbreak, China was ostracized by the international community. With these bitter experiences, the Chinese government has felt an overwhelming desire to seek cooperation with the international society in providing global public goods for health to its own citizens, as well as to the global community. For example, Premier Wen Jiabao asserted, during the SARS outbreak, 'We [the Chinese government] are a government not only responsible to China's 1.3 billion people, but also to the world' (Chou Wiest 2003b).

Why is China so sensitive to the evaluations made by others in the international community? In the parlance of liberal institutionalism, a good reputation will lead to more favourable terms of engagement for China with other countries, not only in the health regime, but also in other areas, such as trade and human rights. Its compliant behaviour in one issue-area will lower the transaction cost of its participation in other areas (Chayes and Chayes 1995). Chinese culture also attaches importance to good standing in peer groups.

By showing that it behaves responsibly, China strengthens its soft or normative power in the international community. By showcasing itself as a responsible state, China's policy has shifted from a purely Sino-centric worldview to one which stresses China's role in, and its contribution to, global peace and security. By turning this rhetoric into practice, China aims not only at promoting 'good governance' in curtailing the spread of infectious diseases, but also earning a reputation as a responsible great power.

That said, there is no compelling evidence to support the claim that China's compliant behaviour results from a sense of duty or obligation to global efforts to contain the spread of diseases. China has not yet fully internalized the norms of cooperative multilateralism and transparency in reporting and data-sharing. There seems to be little or no fundamental change in the way China perceives itself and others. The Draft Law on Emergency Management constitutes an example. The bill, under review by the Standing Committee of the National People's Congress in June–July 2006, threatens to impose fines, ranging from 50,000 yuan to 100,000 yuan, on news media for reporting on public emergencies with no prior government authorization. Public emergencies include natural disasters, outbreaks of epidemics, and social unrest. Although Chinese officials stress that the law is to upgrade the country's ability to cope with outbreaks of natural and industrial hazards and health crises, critics warn that the law would give much leeway to local governments to cover up outbreaks of public-health crises by forcing mass media to seek approvals before reporting on the outbreaks (China Internet Information Center 2006, Fowler and Qin 2006, Kahn 2006, Ma 2006c). Although the relative importance of the three factors discussed above are difficult to gauge, together they help to increase our understanding of China's behaviour in global health governance.

Conclusion

The three case studies of HIV/AIDS, SARS, and avian flu show that China's increasing participation in global health governance since the turn of the century has been driven by both necessity and conscious design. By admitting its AIDS problem in 2001, China has cemented cooperation with various state and non-state actors. China has skilfully utilized multilateralism to gain access to international resources and technical assistance. Furthermore, its frequent interactions with United Nations agencies have triggered a learning process that has, subsequently, led it to securitize communicable diseases as a security threat. Globalization has accelerated the movement of viruses and diseases across national boundaries. China's practice of hiding domestic outbreaks of diseases has been severely criticized by the international community. International concerns about good governance, particularly after the Asian financial crisis of 1997–1998, have put China under normative pressure to change tack. Obviously, its maladministration of the SARS outbreak has exacerbated other countries' scepticism of China's responsibility to the international community. Wary of being ostracized by the international community, the Chinese government has consolidated its desire to seek cooperation with international society in regard to non-traditional security issues. In the wake of the SARS outbreak in 2003, China's participation in global health governance has, therefore, increased rapidly and become more proactive.

Overall, China's active participation and cooperation, in providing global public goods for health, has made a positive impact on regional as well as international security. The central government is now using an increasingly multilateral and cooperative approach to global health governance. Chinese leaders have shown their determination to combat infectious diseases despite problematic implementation at the local levels. If China's understanding of national sovereignty can continue the current evolutionary process, from a narrow focus on territorial and jurisdictional dimensions to one that allows multilateralism to deal with non-traditional security issues, then it would seem that China is bending toward a post-Westphalian concept of handling public health issues, and would become more flexible in dealing with infectious diseases, regarded as non-traditional security issues.³² However, its concern over territorial and jurisdictional sovereignties, the areas of conventional understanding, is still dominant. The issue of Taiwan's participation in WHO has sparked off a controversy about China's political intervention in providing global public goods for health. It is still uncertain whether a higher level of cooperative behaviour, and compliance with international regulatory rules, exhibited by China, masks short-term utilitarian reasons and whether the anachronistic Westphalian concept of sovereignty would impede an uninterrupted supply of global public goods for health.

In addition, while China has involved a wide range of actors in combating HIV/AIDS inside the country, its tolerance towards the activities of NGOs is frustrating. NGOs and AIDS activists in China continue to face detention and harassment by local authorities. In the wake of 'colour revolutions' in three post-communist states of Georgia, Ukraine, and Kyrgyzstan in 2003–2005, China has expressed concerns about the proliferation of domestic and international NGOs, as well as their operations in China, and goes to great pains to tighten its control over their activities (Saich 2006b).³³ If global health governance depends on good governance at home,

then it would seem that China still has a long way to go toward making substantial contributions to global health governance.

Furthermore, while China often alleges that the prevailing global order favours predominant powers disproportionately, and is, therefore, not conducive to the development of less developed countries, including it (Yu 2002, Shi 2002), as shown in our analysis on the role and nature of China's engagement with global health governance, it is focusing more on gaining credibility with institutions of global governance than challenging the power relations, as well as the core values underpinning the workings of the institutions. Only recently have practitioners in the academic and policymaking circles in China paid scant attention to the discussions about global governance. Therefore, it is not surprising that there has not been any blueprint for reforming China's mechanisms of global governance (Pang 2006).³⁴ Nevertheless, whether China, with increasing economic, political, and normative clout, would comply with global (strictly speaking, Western) norms and rules, without any qualification, is a moot point.

Hence, the debate over whether China will steadfastly engage in global health governance is likely to go on. Actors in the issue-area of public health have reasons to be suspicious of China's present and future motives. Would China change its spots as a consequence of a change of heart resulting from a rise in power? Perhaps the looming avian flu pandemic could provide a litmus test for the country's concern over global health governance.

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Notes

1. The report is available at <http://www.who.int/whr/2000/en/> Accessed 13 February 2007.
2. According to the International Health Regulations, states' international legal obligations are to report outbreaks of cholera, plague, and yellow fever. SARS, a new pathogenic lethal disease, was not included in the regulations by that time. Therefore, strictly speaking, China owed no international legal obligation to involve WHO in addressing the SARS problem within its territory.
3. There is an extensive and growing literature, including Altman (2003), Brundtland (2003), Chen et al. (2003a,b), Heymann (2003), Lee (2003a,b), Curley and Thomas (2004), Prins (2004), Doyle (2006), Elbe (2006), McInnes and Lee (2006). The March 2006 edition of *International Affairs* is devoted to the study of HIV/AIDS.
4. The origins of the 1918 Spanish influenza are under debate. Some scientists believe that it originated in Guangdong, China.
5. For a more detailed account on China's healthcare system, see L.H. Chan (2006).
6. For example, the proportion of spending on preventive care in the government's recurrent health budget dropped from 23% in 1978 to 18% in 1994.
7. A total of 842,525 people in nearly 3,900 townships and towns in China had schistosomiasis (also known as snail fever; *xuexichong bing*) in 2004 and an estimated 30 million are at risk. See 2005 *nian Zhongguo weisheng tongji diyao* [China's Public Health Statistical Digest 2005], Ministry of Health, People's Republic of China. Accessed 1 March 2006, available at www.moh.gov.cn; 2005 *Zhongguo weisheng tongji nianjian* [China's Public Health Statistical Yearbook 2005], p. 246; and Yardley (2005).
8. In 2003, the official figure of the estimated number of HIV/AIDS in China was 840,000. On 25 January 2005, the Chinese government and the UN agencies endorsed the new

figure of 650,000, down by 22%. The Chinese government said the adjustment was mainly caused by its overestimate of the number of people who were infected by illicit blood trading in the 1990s. The government released the news after months of delay because officials feared that a significantly lower number of HIV infections might draw criticism and doubt over the data. Both the Chinese government and the UN agencies agreed that the new estimate was derived from better data collection and calculation models, although some HIV/AIDS activists and NGOs still questioned the reliability of the data. See UNAIDS and WHO (2006).

9. World AIDS Day takes place every year on 1 December.
10. The regulations were approved by the National People's Congress, China's legislature, in January 2006. They stipulate the principles, roles and responsibilities of government departments at national and local levels in the prevention and control of HIV/AIDS (Embassy of the PRC in the USA 2006).
11. Dr. Gao, a 78-year-old gynaecologist in Henan province, has been named an AIDS crusader and has fought the scourge of HIV/AIDS since 1996. After exposing the HIV/AIDS epidemic and the misconduct of health officials and private entrepreneurs in the collection and dissemination of blood in the province, Dr. Gao was accused of being 'anti-government'. In the wake of a 3-hour private meeting between Wu Yi and her (with the exclusion of Henan officials) during Wu's visit to the province in December 2003, the central government began to be more tolerant of her activities in the country. The national China Central Television (CCTV) honoured her with the 'Touching China' award in February 2004. In addition, she recently got her new books, *Yiwan fengxin* [*Ten Thousand Letters*] (2004), and *Zhongguo aizibing tiaocha* [*The Investigation of AIDS in China*] (2005) published. The books reveal her encounters in AIDS villages in the province. Interestingly, the first book was published by the Chinese Academy of Social Sciences (CASS), a government think-tank in Beijing. See, among others, *Agence France-Presse* (2004).
12. Wan Yanhai, head of the Beijing Aizhixing Institute of Health Education, was put in jail for 27 days in 2002, for posting on his website a Henan government document about the HIV/AIDS outbreak there, and detained for a month in the following year for receiving a classified document showing that the provincial officials were aware of the AIDS problem long before their formal acknowledgement of it. See Pomfret (2003) and Russell (2006).
13. Li Qianji was a clinic worker at the Xingtai Blood Centre in Hebei province in northern China. After appearing on a TV programme on 13 August 2004, about the problems with Xingtai's blood supply in which Li revealed dangerous practices of blood collection and the sale of tainted blood and plasma to Shanghai, Beijing, and Hebei in the 1990s, Li's monthly salary was cut from a normal 1,500 yuan to 2.75 yuan in February 2005. The Centre's director claimed that his salary cut was triggered by pressure from the provincial government. See S.S. Chan (2005).
14. The 'Four Frees and One Care' policy is a nationwide policy to provide: (a) Free ARV drugs to AIDS patients who are rural residents, or people with financial difficulties living in urban areas; (b) Free Voluntary Counselling and Testing (VCT); (c) Free drugs to HIV infected pregnant women to prevent mother-to-child transmission, and HIV testing of newborn babies; (d) Free schooling for children orphaned by AIDS; and (e) Care and economic assistance to the households of people living with HIV/AIDS. See MOH et al. (2006).
15. The former party secretary of Shangcai, Yang Songquan, and other local officials, were allegedly arrested in June 2006 for appropriating 10 million yuan in HIV/AIDS-prevention funds.
16. Accordingly, Wen Jiabao did not physically attend the conference, but his message was recorded on a videotape shown at the conference.
17. She was harassed by Henan officials in November 2003 when she went to Tsinghua University, Beijing, to attend an AIDS and SARS summit to which Bill Clinton delivered a speech (Spencer 2004).
18. Wu Yi is regarded as the 'Chinese iron lady', renowned for her toughness in negotiations with the USA and other nations on China's World Trade Organization membership drive while she was the Foreign Trade Minister.

19. Interestingly, the SARS outbreak has some positive impacts on China's engagement with regional and international institutions, particularly on non-traditional security issues. Its cooperation with ASEAN on non-traditional security issues has increased and the scope has been expanded to various non-traditional security issues, ranging from public health to finance and to natural resources (see Tang and Zhang 2003). Accordingly, discussions about non-traditional security among Chinese leaders and scholars have started to appear after the SARS outbreak in 2003. For instance, with the first research project on 'China and non-traditional security issues' undertaken in September 2003, the first national academic conference on the issue was held in Beijing in December 2003, under the auspices of the Institute of World Economics and Politics at the Chinese Academy of Social Sciences. In order to strengthen dialogues about how to address non-traditional security threats in the era of globalization, *Shijie jingji yu zhengzhi* [*World Economics and Politics*], a monthly academic journal, published by the Institute of World Economics and Politics, has run a special column on 'non-traditional security studies' since 2003 (see Wang 2004).
20. Jiang is a retired Chinese People's Liberation Army (PLA) doctor and Communist Party member. He disclosed the under-reporting of SARS cases in Beijing to *Time* magazine in early April 2003. He told the magazine that in order to ensure that the National People's Congress and the Chinese People's Political Consultative Conference could be convened smoothly by that time, medical staff in the Beijing's military hospitals were warned not to publicize any information about SARS. Countering the official figure of SARS infections at 19, with four dead in Beijing, Jiang alleged that in the No.309 PLA Hospital alone, there were 60 confirmed SARS patients, of whom seven had died. The exposure by him directly altered the government's response to the illness. On 20 April, Deputy Health Minister Gao Qiang said that Beijing had 346 patients with SARS, almost 10 times the number the ministry had previously acknowledged just a few days before.
21. For that reason, when China's Agriculture Ministry announced on 15 November 2005 that it would vaccinate all of the country's 5.2 billion chickens and other poultry in order to guard against bird flu, various scientists held that China's bird flu plan could trigger a backfire on China. The effect of prophylactic use of antiviral drugs in the absence of a human outbreak is still controversial. Substandard vaccines or an improper vaccinating procedure could spread the virus easily. See French (2005) and McNeil (2005).
22. During the conference in Beijing, US\$1.9 billion was pledged by 33 countries and international institutions, of which \$334 million was from the USA, \$159 million from Japan, and \$120 million from the EU. China committed \$10 million in total. China's financial contribution was criticized for being relatively little, especially in comparison with the USA and Japan. Beijing officials have defended that as a developing country and home to one third of the world's population of birds, China needs to spend its money to combat the disease at home. See Bradsher (2006) and *People's Daily Online* (2006).
23. China blamed the US Centers for Disease Control and Prevention for causing a prolonged delay in the delivery of the virus samples. Julie Hall of WHO's Beijing Office, however, disputed the Chinese account (*Dow Jones International News* 2006, Zhao 2006). One day after Chan's election, China sent 20 samples to a WHO collaborating laboratory in the USA (Benitez et al. 2006).
24. Jiang Zuojun, Vice Health Minister, attributed the delay in identifying and confirming the bird flu case to a lack of communication between researchers and health officials rather than any deliberate cover-up. Until December 2004, China's research institutes were not required by law to report infectious diseases. Although this retrospective diagnosis has caused concerns as to whether there might have been other unidentified human bird-flu infections in China, the Chinese government refuses to re-examine other samples. Health experts have suspected that the virus was present in China in 2003. Several members of a Hong Kong family succumbed to the virus in Fujian in January–February 2003. An 8-year-old girl died and was buried there before local doctors could identify the cause of her death, and her 9-year-old brother and her father were diagnosed with bird flu on their return to Hong Kong. Later her father died in Hong Kong. But Fujian officials insisted that the family did not contract the virus in the province and that the girl died of

- pneumonia. See Lee and Benitez (2003), Zheng and Hu (2003), *China Daily* (2006b), Kwok (2006), *Wall Street Journal Asia* (2006).
25. Compliance studies have shown that an actor's compliant behaviour could be motivated by both utilitarian and non-utilitarian reasons. See Chayes and Chayes (1995) and Young (1979).
 26. The first application that China lodged to the Global fund was rejected in early 2002, due to its unreliable statistics and closed attitude towards its HIV/AIDS problem. The government submitted its application again later that year. See Rosenthal (2002).
 27. In 2004 and 2005, China was granted by the Global Fund a total of US\$56 million to tackle HIV/AIDS. In July 2006, the Global Fund signed an agreement on grant of US\$12.5 million for HIV/AIDS work with China. *The Global Fund to Fight AIDS, Tuberculosis and Malaria*, available at <http://www.theglobalfund.org/programs/Portfolio.aspx?countryID=CHN&lang=en> (accessed on 12 July 2006) and Dickie (2006a).
 28. The 'Beijing Declaration and Platform for Action' was adopted at the 4th World Conference on Women in Beijing in 1995.
 29. The key advocate was Richard Holbrooke, the then US ambassador to the UN. He pushed the Security Council to recognize the global HIV/AIDS threat after visiting Zambia in December 1999. Having overcome the opposition from Russia and China, which ultimately relented and did not take part in the debate, the USA followed through the deliberation and led to the passage of the resolution. See UN Security Council, Resolution 1308 (2000), Sternberg (2002), and Prins (2004).
 30. Wang Yizhou of the Institute of World Economics and Politics at the Chinese Academy of Social Sciences argues that 'low politics' should enjoy the same degree of importance as 'high politics' in order for China to be able to handle non-traditional security issues successfully (Wang 2006).
 31. In terms of threat to security, SARS was equated with the September 11 terrorist attacks on the USA (Zhang 2003).
 32. Owing to China's increased participation in global governance, and its growing self-identity as a responsible great state after decades of rapid economic development, China's understanding of sovereignty has undergone a gradual evolution, shifting from a traditional concept that proclaims the centrality of the principle of non-intervention in internal affairs to one that embraces international cooperation and multilateralism in treating non-traditional security issues. In this paper, we deal with the spread of infectious diseases, which is regarded as one of non-traditional security threats. Despite the fact that it is still wary about external interventions and the fact that its conceptualization of non-traditional security threats is in large measure a state-centric concept, China has become more flexible and willing to cooperate with various actors both inside and outside the country. For a detailed account on the changing Chinese stances on sovereignty, see Carlson (2005). Wang Yizhou has also suggested that it would be sensible to adopt a flexible approach to understand sovereignty in the age of globalization, besides studying it purely from the perspective of international law. Sovereignty, according to him, is more than ever before bound to the obligation to protect human rights of the local populace. Failure to respect, defend, and promote human rights within one's territory would call into question the very legitimacy of the state. See his (2000) *Zhuquan fanwei zai sikao* [rethinking the scope of sovereignty], *Ouzhou* (Europe), 6, 4-11; and *SARS yu fei chuantong anquen* [SARS and non-traditional security] at <http://test.aiwep.org.cn/info/content.asp?infol=1981> Accessed 30 September 2007.
 33. More than 60 Chinese NGOs accused the Chinese government of excluding them from participation in the April 2006 election of representatives to the Chinese coordinating board of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The board is responsible for distributing and overseeing grants worth more than US\$300 million. See Blanchard (2006b), *Reuters News* (2006), and Dickie (2006b).

34. Obviously, the younger generation of International Relations scholars in China show a stronger interest in using Western theories to study global governance than their predecessors. Su Changhe of Shanghai's Fudan University, born in 1971, examines global governance and international co-operation from the perspectives of global public issues, global public goods, and international regimes. As far as the authors are concerned, however, the discussion remains largely an introduction to the theories. See Su Changhe (2000).

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